# WHO – ASSIST V3.0

**Introduction:**

Thank you for agreeing to take part in this brief questionnaire about alcohol, tobacco products, and other drugs. This questionnaire contains some questions about your experience of using these substances across your lifetime and in the last three months. These substances can be smoked, swallowed, snorted, inhaled, injected, or taken in the form of pills.

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this questionnaire, do not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please indicate that.

**Instructions:**

**Please circle the response option that best describes your answer to each question. Follow all instructions between questions, and complete ALL questions to compute your score.**

## Question 1.

| **In your life, which of the following substances have you ever used? (NON-MEDICAL USE ONLY)** | **No** | **Yes** |
|---|---|---|
| a. Tobacco products (Cigarettes, Chewing Tobacco, Cigars, etc) | **0** | **3** |
| b. Alcoholic beverages (beer, wine spirits, etc.) | **0** | **3** |
| c. Cannabis (marijuana, pot, grass, hash, etc.) | **0** | **3** |
| d. Cocaine (coke, crack, etc.) | **0** | **3** |
| e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.) | **0** | **3** |
| f. Inhalants (nitrous, glue, petrol, paint thinner, etc.) | **0** | **3** |
| g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, ect.) | **0** | **3** |
| h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.) | **0** | **3** |
| i. Opiods (heroine, morphine, methadone, codeine, etc.) | **0** | **3** |

**If you answered NO to all items, stop questionnaire and see the answer sheet.**
**If you answered YES to any item, complete Question 2 for those substances.**

***Please continue to the next page →***

## Question 2.

| **In the past three months, how often have you used the substances above (FIRST DRUG, SECOND DRUG, ETC.)?** | **Never** | **Once or Twice** | **Monthly** | **Weekly** | **Daily or Almost Daily** |
|---|---|---|---|---|---|
| a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.) | 0 | 3 | 4 | 5 | 6 |
| b. Alcoholic beverages (beer, wine, spirits, etc.) | 0 | 3 | 4 | 5 | 6 |
| c. Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 3 | 4 | 5 | 6 |
| d. Cocaine (coke, crack, etc.) | 0 | 3 | 4 | 5 | 6 |
| e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.) | 0 | 3 | 4 | 5 | 6 |
| f. Inhalants (nitrous, glue, petrol, paint thinner, etc.) | 0 | 3 | 4 | 5 | 6 |
| g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.) | 0 | 3 | 4 | 5 | 6 |
| h.Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.) | 0 | 3 | 4 | 5 | 6 |
| i. Opiods (heroin, morphine, methadone, codeine, etc.) | 0 | 3 | 4 | 5 | 6 |

**If you answered Never to all items in Question 2, skip to Question 6.**
**If any substances in Question 2 were used in the previous 3 months, continue with Questions 3, 4, & 5 for each substance used.**

## Question 3.

| **During the past three months, how often have you had a strong desire or urge to use (FIRST DRUG, SECOND DRUG, ETC.)?** | **Never** | **Once or Twice** | **Monthly** | **Weekly** | **Daily or Almost Daily** |
|---|---|---|---|---|---|
| a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.) | 0 | 3 | 4 | 5 | 6 |
| b. Alcoholic beverages (beer, wine, spirits, etc.) | 0 | 3 | 4 | 5 | 6 |
| c. Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 3 | 4 | 5 | 6 |
| d. Cocaine (coke, crack, etc.) | 0 | 3 | 4 | 5 | 6 |
| e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.) | 0 | 3 | 4 | 5 | 6 |
| f. Inhalants (nitrous, glue, petrol, paint thinner, etc.) | 0 | 3 | 4 | 5 | 6 |
| g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.) | 0 | 3 | 4 | 5 | 6 |
| h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.) | 0 | 3 | 4 | 5 | 6 |
| i. Opioids (heroin, morphine, methadone, codeine, etc.) | 0 | 3 | 4 | 5 | 6 |

***Please continue to the next page →***

## Question 4.

| **During the past three months, how often has your use of (FIRST DRUG, SECOND DRUG, ETC.) led to health, social, legal, or financial problems?** | **Never** | **Once or Twice** | **Monthly** | **Weekly** | **Daily or Almost Daily** |
|---|---|---|---|---|---|
| a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.) | 0 | 3 | 4 | 5 | 6 |
| b. Alcoholic beverages (beer, wine, spirits, etc.) | 0 | 3 | 4 | 5 | 6 |
| c. Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 3 | 4 | 5 | 6 |
| d. Cocaine (coke, crack, etc.) | 0 | 3 | 4 | 5 | 6 |
| e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.) | 0 | 3 | 4 | 5 | 6 |
| f. Inhalants (nitrous, glue, petrol, paint thinner, etc.) | 0 | 3 | 4 | 5 | 6 |
| g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.) | 0 | 3 | 4 | 5 | 6 |
| h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.) | 0 | 3 | 4 | 5 | 6 |
| i. Opioids (heroin, morphine, methadone, codeine, etc.) | 0 | 3 | 4 | 5 | 6 |

## Question 5.

| **During the past three months, how often have you failed to do what was normally expected of you because of your use of (FIRST DRUG, SECOND DRUG, ETC.)?** | **Never** | **Once or Twice** | **Monthly** | **Weekly** | **Daily or Almost Daily** |
|---|---|---|---|---|---|
| a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.) | n/a | | | | |
| b. Alcoholic beverages (beer, wine, spirits, etc.) | 0 | 3 | 4 | 5 | 6 |
| c. Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 3 | 4 | 5 | 6 |
| d. Cocaine (coke, crack, etc.) | 0 | 3 | 4 | 5 | 6 |
| e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.) | 0 | 3 | 4 | 5 | 6 |
| f. Inhalants (nitrous, glue, petrol, paint thinner, etc.) | 0 | 3 | 4 | 5 | 6 |
| g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.) | 0 | 3 | 4 | 5 | 6 |
| h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.) | 0 | 3 | 4 | 5 | 6 |
| i. Opioids (heroin, morphine, methadone, codeine, etc.) | 0 | 3 | 4 | 5 | 6 |

**Complete Questions 6 and 7 for all substances ever used (i.e. those endorsed in Question 1.)**

***Please continue to the next page →***

## Question 6.

| **Has a friend or relative or anyone else <u>ever</u> expressed concern about your use of (FIRST DRUG, SECOND DRUG, ETC.?)** | **No, Never** | **Yes, in the past 3 months** | **Yes, but not in the past 3 months** |
|---|---|---|---|
| a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.) | **0** | **6** | **3** |
| b. Alcoholic beverages (beer, wine, spirits, etc.) | **0** | **6** | **3** |
| c. Cannabis (marijuana, pot, grass, hash, etc.) | **0** | **6** | **3** |
| d. Cocaine (coke, crack, etc.) | **0** | **6** | **3** |
| e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.) | **0** | **6** | **3** |
| f. Inhalants (nitrous, glue, petrol, paint thinner, etc.) | **0** | **6** | **3** |
| g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.) | **0** | **6** | **3** |
| h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.) | **0** | **6** | **3** |
| i. Opioids (heroin, morphine, methadone, codeine, etc.) | **0** | **6** | **3** |

## Question 7.

| **Have you <u>ever</u> tried and failed to control, cut down, or stop using (FIRST DRUG, SECOND DRUG, ETC.)?** | **No, Never** | **Yes, in the past 3 months** | **Yes, but not in the past 3 months** |
|---|---|---|---|
| a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.) | **0** | **6** | **3** |
| b. Alcoholic beverages (beer, wine, spirits, etc.) | **0** | **6** | **3** |
| c. Cannabis (marijuana, pot, grass, hash, etc.) | **0** | **6** | **3** |
| d. Cocaine (coke, crack, etc.) | **0** | **6** | **3** |
| e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.) | **0** | **6** | **3** |
| f. Inhalants (nitrous, glue, petrol, paint thinner, etc.) | **0** | **6** | **3** |
| g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.) | **0** | **6** | **3** |
| h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.) | **0** | **6** | **3** |
| i. Opioids (heroin, morphine, methadone, codeine, etc.) | **0** | **6** | **3** |

***Please continue to the next page →***

## Question 8.

| | No, Never | Yes, in the past 3 months | Yes, but not in the past 3 months |
|---|---|---|---|
| **Have you <u>ever</u> used any drug by injection? (NON-MEDICAL USE ONLY)** | **0** | **2** | **1** |

**If you answered <u>Yes</u> to this question, please see the *Risks of Injecting* attachment.**

After you have finished this questionnaire, please download and print your "Answer Sheet", fill out each of the rows and tally your score.
Then, read about what your scores mean, and download and print the "Health Risks" sheet for more information about how your risk may impact your overall health.

**Thank you for taking an active role in learning about your health!**